PRESIDENTIAL ADDRESS

From the Southern Association for Vascular Surgery

Vascular surgery, self-awareness, and the University of South Carolina School of Medicine Greenville

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As the nation labors to address the challenges of its health care system, physicians often complain that they are under-represented in regard to decision making; particularly policy decisions that affect their well-being and that of their patients. If more physician leaders were available and engaged, it is logical to assume that better solutions might emerge. In this regard, I believe that surgeons represent an underutilized resource. In most cases, surgeons are intelligent, disciplined, and capable of leading teams to achieve complex objectives. History is replete with champions who have advanced the field of surgery, leaders such as DeBakey, Halstead, and Blalock. However, leaders who have made lasting policy contributions beyond the field of surgery are uncommon. I have often wondered why this is.

Today, the practice of medicine in the United States is in transition. While we have unprecedented capabilities, we are limited by our inability to deliver treatment in a reliable cost effective manner. As eloquently described by Dr Donald Trunkey in his Presidential Address read before the 2010 Annual Meeting of the American Surgical Association, our medical system in America is challenged by failures of access, cost, and quality.[1] Similarly, as our physician workforce has become more gender diverse and our training paradigms constrained, we have found our medical education system incapable of meeting society's workforce needs. Reform is badly needed. Trunkey and others have made the plea that we, with our surgical personalities, are well suited to lead the reform. He argues that the traits that make surgeons successful leaders in the operating room should be adaptable to make successful leaders outside the operating room.

From the Greenville Hospital System.
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While much has been stereotyped about the surgical personality, literature to support its existence is modest and based on rather soft behavioral and observational data. Neuroscience data on the surgical personality does not exist. In fact, neuroscience investigation for the basis of all human behavior is relatively new, a process chronicled by Dr Richard Davidson in his 2012 book entitled *The Emotional Life of Your Brain*.[2] Other psychologists such as Howard Gardner, Peter Salovey, and John Mayer pioneered emotional behavior research in the 1970s and 80s and author Daniel Goleman coined the phrase "emotional intelligence" in his 1995 book by the same title. When tools to measure personality type, like the Myers-Briggs Type Indicator, are applied to surgeons, there is evidence to substantiate the existence of the surgical personality.[3,4] Data show that surgeons tend to be extroverted, open-minded, and conscientious. They have relatively low regard for harm avoidance and reward dependence.[4,5] Surgeons tend to be assertive, often welcome conflict, and embrace being in control. Surgeons' motivation for control, according to experts, is not necessarily externally focused, like taking control for the welfare of their patients, but rather to avoid self-emotional vulnerability. Loss of control equates to perceived lack of strength; lack of strength makes the individual vulnerable to physical or emotional harm. Surgeons enjoy the perception of strength and are quite comfortable being "the captain of the ship." Additionally, there are data to support that these traits are not gender specific; females in surgery possess similar traits to males.[5,6] It is important to note the limitations of the existing literature. Specifically, studies addressing the topic are usually performed on populations at a single temporal point. They do not account for personality changes, which may accompany physiologic aging or environmental influences.

The concept of personality change and purposeful personality transformation, in particular, are well substantiated in the fields of psychology, theology, and more recently, neuroscience. Often, we refer to such transformation, when it is positive, as personal growth or development of emotional intelligence. Though frequently employed outside of health care, the use of emotional intelligence, especially in the area of developing physician leadership, is uncommon. I became aware of this in 2007 shortly after Michael C. Riordan became President and Chief Executive Officer of the Greenville Hospital System (GHS). Mr

Riordan brought the concept of emotional intelligence and conscious leadership to his senior management team, which included me as a department chair, shortly after his arrival in 2006. In doing so, he introduced us to a professional acquaintance with whom he had worked at the University of Chicago prior to coming to Greenville. This acquaintance, who described himself as an "executive coach," became our Teacher, coaching the Greenville Hospital System's senior management team on a regular basis. One of the tenets we learned was that while personality style is largely ingrained by adulthood, leaders can nurture their emotional intelligence through "conscious leadership" to promote authentic communication, a quality, the Teacher argued, as essential for high performing corporate or health care delivery teams. He introduced the notion of low functioning, medium functioning, and high functioning personality styles. The Teacher showed evidence that the stereotypical traits often attributed to surgeons, like "being captain of the ship," can manifest quite differently depending on the level of emotional maturity. For example, the surgical personality, he explained, can be found with equal prevalence in the operating room as it can in the federal prison system. The same traits that make surgeons strong, successful, inspirational leaders are often the same traits that make criminals wayward, self-absorbed bullies. The difference is the degree of emotional maturity; maturity that can evolve with the right training. Assuming this to be true, what role, then, does emotional intelligence (or the lack of) play as an enabler or a barrier to surgeons wanting to fulfill their leadership potential?

It is my hypothesis that the lack of emotional intelligence, and more specifically, the lack of self-awareness, is a major blind spot for most surgeons and is, thus, a significant barrier to leadership beyond our traditional domain.

THE UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE GREENVILLE: A PERSONAL JOURNEY OF SELF-AWARENESS

While surgical educators often complain about undergraduate medical education and its failure to properly prepare medical graduates for the rigors of surgical residency, they typically do not involve themselves in the administration and curricular affairs of medical school. An opportunity to change this happened in 2009.

Dr Jerry Youkey, a vascular surgeon and member of the Southern Association for Vascular Surgery, serving as the GHS Vice President of Academic and Physician Services, approached me in 2008 and asked that I take on additional academic administrative responsibilities at GHS. Toward the goal of succession planning, I assumed the role of assistant dean for academic affairs in addition to my role as chair of surgery. At the time, GHS was a regional campus for the University of South Carolina School Of Medicine (USCSOM) based 90 miles away in Columbia, a designation it has maintained since 1991. As a regional campus, GHS is the clinical education home for 25% to 30% of the USCSOM medical school class. Following the M2 year, approximately 30 students move and complete their medical education in Greenville, utilizing the clinical resources of GHS. One of my first tasks as assistant dean was to unofficially examine the potential of expanding undergraduate medical education in Greenville. Eager to impress, I quickly reached out to Dr Edward C. Floyd, another vascular surgeon from Florence, SC, and an old acquaintance, for assistance. Dr Floyd is an influential member on the University of South Carolina (USC) Board of Trustees and a bona fide battlefield commissioned expert in University political and administrative affairs. Working collaboratively, we discovered the Association of American Medical Colleges call for a 30% increase in medical school enrollment; an increase they believed necessary to mitigate the looming 90,000 physician shortage by 2020. As well, we surveyed the capacity for GHS to expand undergraduate medical education. We quickly assessed that GHS, with its 1200 beds, five regional campuses, and approximately 1000 employed providers, had the capacity to support a 4-year medical school campus. After reporting our findings, USC President Harris Pastides, PhD, and GHS President Michael Riordan, working with their respective Boards, charged a committee, chaired by me, to study the feasibility of a 4-year medical school campus at GHS. Working through the summer of 2009, the committee reported its findings to a subcommittee of the USC Board of Trustees in August. This culminated in the creation of a business planning committee co-chaired by USC immediate Past President Andrew Sorensen, PhD, and myself (Fig 1). This committee created a business plan for a new medical school in Greenville, the second medical school for the University of South Carolina. In June 2010, the respective Boards of Trustees for USC and GHS simultaneously approved the expansion of the medical school campus in Greenville. As required by the Liaison Committee on Medical Education (LCME), the accreditation body for medical schools, an Institutional Self-Study Task Force involving more than 100 faculty and administrators was formed to prepare the nearly 1500-page LCME application (database and self-study) for the new school (Fig 2). I chaired the Self-Study Task Force and was editor and coauthor of the LCME documents. The documents were submitted to the LCME in April 2011. Following a July site visit, USCSOM Greenville received Preliminary Accreditation from the LCME in the fall of 2011 and admitted its charter class the following year.

Leading like a bandleader. Early on in the medical school development process, Dr Youkey and I realized the unique opportunity presented to us. This was a chance to "fix undergraduate medical education"; to create the perfect medical school graduate, able to enter graduate medical education and quickly emerge as a superstar. During the feasibility study, we used our surgical "take charge" personality traits to craft the optimal preclinical curriculum, objectives and all, along with an early draft of our Guiding Principles (a more refined copy shown in the Table). I quickly "ushered" these through committee and believed that we were well on our way to creating the

Fig 1. The business planning committee for the University of South Carolina School of Medicine Greenville co-chaired by Drs Andrew Sorensen and Spence Taylor (From *right*: Steve Sloate, Donald DiPette, MD, Malcolm Isley, Andrew Sorenson, PhD, Spence Taylor, MD, Brenda Thames, EdD, Sandra Burns, and James Buggy, PhD).

Fig 2. Dr Spence Taylor and the medical school application for the University of South Carolina School of Medicine Greenville just prior to submission to the Liaison Committee for Medical Education.

perfect doctor—the master clinician capable of advancing medical care and driving health care reform.

It was early in the business-planning phase that I received a "wake-up call." I quickly learned that starting a medical school, more than anything, involved managing timelines. There was never enough time. As such, I approached the work as I would any departmental problem. I set expectations for the committee and drove the process. One day, my business planning committee cochair, Dr Andrew Sorensen, approached me and warned that I had little chance of success if I were to continue managing the process as I was. "Just like all surgeons, you lead like a band leader. You're oblivious to your surroundings and you run over people to get your way." He went on to explain, "To be successful, you need to lead more like a shepherd. You need to lead the herd from behind."

It is important to note that Dr Sorensen was former Provost at the University of Florida and Past President at the University of Alabama and the University of South Carolina. He possessed a larger-than-life personality that was both compassionate and forceful. His achievements as an academic administrative leader are too numerous to recount. His comments about my leadership were stunning. I was completely unaware and forlorn to hear such an assessment from a man I admired so much. Defensively, I explained that we do not have the time to let our committees wander aimlessly like sheep. Unabashed, he offered to demonstrate at the next committee meeting, a meeting where three crucial decisions needed to be made. Moreover, Dr Sorensen and I both had strong opinions about what the decisions should be—the perfect scenario for a band leader so I thought. As Dr Sorensen convened the committee meeting, I watched skeptically. He succinctly presented the issues and asked the committee members to consider three problems that needed decisions. He opened up the committee for discussion where a variety of seemingly extraneous, irrelevant solutions emerged from the group. Sorensen listened patiently. Suddenly, one of the committee members mentioned a solution analogous to what we had believed to be the right solution. Dr Sorensen quickly acknowledged the committee member and praised her proposed solution as an interesting idea. As other committee members weighed in, Dr Sorensen stood up and wrote the solution on the whiteboard. Next, he solicited opinions regarding the other two decisions and in a similar fashion, coerced "the right answer" as well as an original idea of merit we had not previously considered. He wrote them on the whiteboard as well. At the end of the hour, he thanked the committee and closed the meeting. After the members left, all very pleased that they had made lasting contributions to the medical school, Dr Sorensen turned to me and said, "That's how you lead like a shepherd, Son."

This "wake-up call" made a profound impact. Moreover, it connected back to the leadership offerings of our corporate Teacher; who stressed self-awareness as the central element to effective leadership. For the first time, I realized I had very little self-awareness. Had the Teacher, whom I had deemed as amusing but of only moderate relevance, been speaking to me? As I looked back at the materials I had amassed from the many sessions I had attended, the Teacher's message suddenly gained a sense of renewed importance and personal relevance. During his sessions, the Teacher explained that in his observations, people tend to experience the world in one of four ways, graphically depicted by four boxes (Fig 3). The most common way people experience their surroundings is in a "to me" or victim mentality. Alternatively stated, the activities of the world are happening to them; they are victims at the effect of some outside force or circumstance that is creating their feeling state and

Table. The guiding principles for University of South Carolina School of Medicine Greenville

Guiding principles
1. USCSOM-Greenville will be responsive to the changing health care needs of our society.
2. USCSOM-Greenville will strive to consider the needs of the students, faculty, and administration in a manner which enhances the stature of both USC and GHS.
3. USCSOM-Greenville understands that health care delivery is constantly evolving and that its physician graduates should facilitate and advocate transformation that improves care provision.
4. USCSOM-Greenville will be integrated with all aspects of the GHS delivery system.
5. USCSOM-Greenville will graduate physicians who understand and participate in research that compares the relative clinical effectiveness and outcomes of various treatments.
6. USCSOM-Greenville supports development of a health care workforce that reflects future societal needs and the diversity of the communities served.
7. USCSOM-Greenville will educate physicians to be champions for patient safety, standardization, evidence-based care, and quality; responsive to the medical needs of their community; sensitive to the societal cost of medicine; activists for the education of the future health care workforce; and practitioners that care for all patients regardless of race, social stature, or ability to pay.
8. USCSOM-Greenville students will practice patient-centered care that values the interdependent roles of health care providers and facilities in service to their patients.
9. USCSOM-Greenville will produce physicians competent not only in medical knowledge, technical skill, and patient care, but also in compassion, collaborative interpersonal communication, professional responsibility, and ethical behavior.
10. USCSOM-Greenville believes that candidates for medical school who value professionalism and possess exceptional interpersonal communication skills can be prepared, identified, and selected to become successful practicing physicians.
11. USCSOM-Greenville will establish a learning environment that emphasizes the relationship between undergraduate medical education and the real world of patient care.
12. USCSOM-Greenville strives to alleviate the cost of medical education as a significant barrier to student matriculation and graduation, or as a factor in the selection of a career specialty.
13. USCSOM-Greenville utilizes policies and procedures that synergistically combine the academic virtues of USC with the operational efficiencies of the GHS health system to the benefit of its students, faculty, and staff.
14. USCSOM-Greenville faculty will emphasize and demonstrate the clinical import of the materials that they teach.
15. USCSOM-Greenville faculty selection, development, and promotion processes will favor those committed to their profession as a calling; who view their teaching ability as a gift and privilege.
16. USCSOM-Greenville graduates will be fully prepared and highly competitive to enter graduate medical education.
17. USCSOM-Greenville appreciates that access to medical information is constantly changing and that educational focus must continually emphasize methods to optimally acquire the most current knowledge.
18. USCSOM-Greenville will utilize educational resources, infrastructure, and technology in a fiscally responsible manner, incorporating external resources in the education of health care students when advantageous.

GHS, Greenville Hospital System; *USC,* University of South Carolina; *USCSOM,* University of South Carolina School of Medicine.

dictating their actions. People in "to me" mentality lack self-awareness and often complain and blame others for their feelings and actions. Examples are numerous. You may find yourself unhappy because your children failed to meet some desired expectation or angry because the program committee rejected the abstract you submitted for consideration to the scientific program. In these examples, you are at the effect of your children's behavior or the actions of the program committee. You blame and complain and center your unhappiness on the actions of someone else. People with a keen sense of self-awareness understand that the source of one's feelings are not external but originate internally. As such, people with this insight strive to experience life in a "by me" mentality. They shift from a "to me" mentality by taking healthy responsibility for what they are contributing to the situation. They understand that they themselves are the source of their feeling states, not someone or something else. In other words, maybe you were the reason your paper was rejected by the program committee. Had it been of better quality perhaps it would have received better consideration. People in the "by me" strive to co-create there life situations and exist in an intense state of appreciation. They are curious as to why they choose to feel and see things the way they do and constantly inquire what it is about them that is contributing to their feeling state. Living in "by me" requires intense self-awareness. This self-awareness challenges us to show up in the world differently. It challenges us to reveal, not conceal; to be present, not right; to participate, not control; to be curious, not defensive; and to be appreciative, not entitled (Fig 4). Next, our Teacher explained that further evolution is possible; it is possible to experience the world in "through me" mentality. This requires total surrender and intense awareness. People experiencing the world in "through me" are accepting that something is trying to emerge through them and then have the ability to surrender to let it happen. Lastly, our Teacher explained that low, medium, and high functioning personality styles correlate with and strongly influence how we choose to experience the world. Low performing personality styles are firmly entrenched in "to me" mentality. They are victims at the effect of the world. Medium and high performing personality styles, on the other hand, tend to experience the world more frequently in the "by me" and occasionally in "through me." If our personality styles are going to evolve, the Teacher stressed that the key essential element is

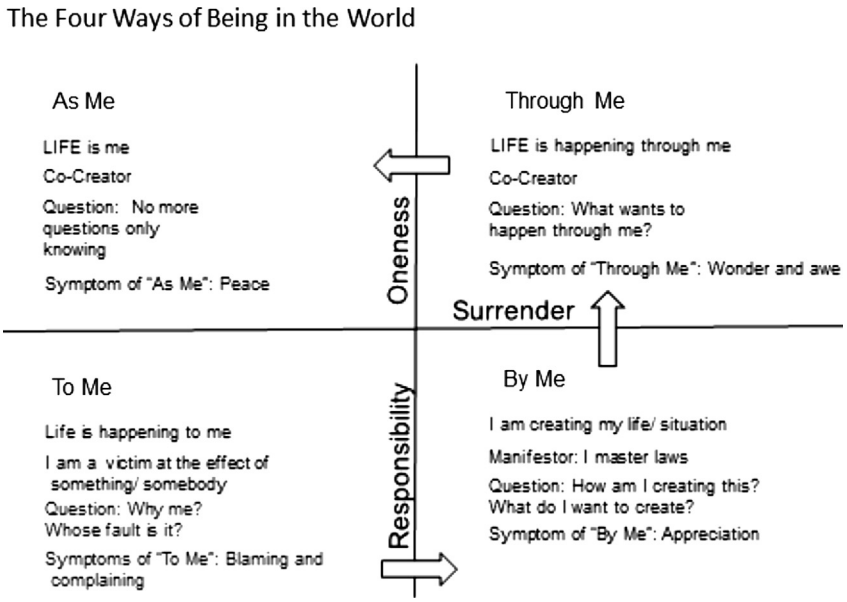

Fig 3. The four ways people experience the world according to our Corporate Teacher.

self-awareness; a constant query of how we are showing up in a given situation to the outside observer.

My personal epiphany: The problem was not that I led as a band leader but that I had no insight into how I was leading or even any awareness of how I was showing up when it was time to lead.

THE LIFE COACH: TRANSFORMATION FROM "TO ME" TO "BY ME"

The actual work of creating a medical school occurs during the LCME directed institutional self-study. This requires the population of a database, a detailed survey of existing resources, processes, and personnel available to establish and maintain a medical school. Next, subcommittees are created to perform an institutional self-study in the areas of institutional setting, educational programming, faculty affairs, student affairs, and educational resources. The final product is an in-depth document that serves as a medical school application to the LCME. The process is iterative, laborious, and forces the institution to address thousands of details. To help with the process, we hired a consultant. When charging the consultant, we requested two services: assistance with the creation of the documents and knowledge transfer, fearing that once the consultant left, no one would know what was in the documents or the details on how to actually run our medical school.

I first met the Consultant assigned to USCSOM Greenville in the spring of 2010. She was a highly intelligent, motivated, experienced, young woman with a heart of a lion and the patience of Job. The deal was struck; she was going to help us design our medical school and teach us how to run it. The person she had to teach was me—a vascular surgeon and surgery department chair in a nonuniversity teaching hospital. The rules were simple. I (or someone I assigned) would write the first draft of all documents as the subcommittees conducted the self-study. The Consultant, who agreed to stay in Greenville 3 days a week, would review and edit my drafts daily.

The work was labor-intensive, characterized by massive workloads and extraordinarily compressed timelines. As with most scholarly activity, writing occurred at night, early mornings before work, and on weekends. I attended every subcommittee meeting, trying my best to look like a shepherd, and took notes. I met with the Consultant for hours. She patiently taught me where the focus of the subcommittees needed to be directed. I quickly learned that the Consultant was a wonderfully brutal perfectionist who rarely slept and was committed to converting me into a medical school administrator. Drafts of documents I sent early morning by e-mail were returned at night often slaughtered by track changes and even an occasional comment of "Unacceptable. Please rewrite."

As the work continued, it became obvious that the project was bigger than I had imagined. Days for me began at 3 AM when I awoke, turned on the coffee maker, and started writing. I arrived at work at 6:40 for vascular surgery morning report and then either attended a subcommittee meeting, met privately with the Consultant, or participated in some patient care activity. Typically, I received my revisions from the Consultant at night. I made the requested edits, staying up as late as I could, and then went to sleep only to start over again the next day. The weekends were used for catch-up. The grind and the timelines were brutal and rivaled what I remembered when I was a vascular resident at Baylor, only I was by then 25 years older. Just when I thought that we were at capacity and barely on schedule,

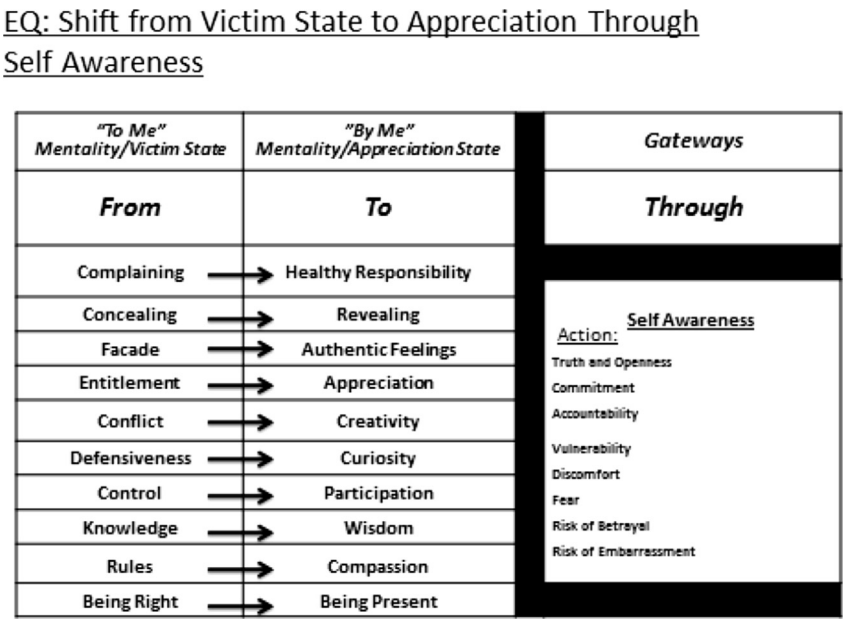

Fig 4. Characteristic behaviors associated with the emotional intelligence states of the "to me" or victim mentality and the more authentic "by me" mentality. Shifting requires intense self-awareness and a desire to change.

the process became more obfuscated. Before the kickoff of the Institutional Self-Study Task Force and the hiring of the Consultant, we had sent multiple overtures to USC administration inquiring about the process for starting new programs. As well, we sent multiple invitations to be part of the Institutional Self-Study Task Force. Curiously, we received only token response and little interest. Then one day, months into the process, we were notified that all documents we were drafting required review, word for word, by the Senior Vice Provost of USC prior to submission to any outside agency (even for consultative review). This meant that many weeks of "completed" work needed to be reopened and re-edited. Unbeknown to us, the new school of medicine in Greenville was the first college to be started at USC in more than 30 years. There was no institutional memory or experience with the process. From the USC perspective, this high profile endeavor was an administrative "first" and was complicated by the circumstances in which it was being created: by vascular surgeons, 90 miles away, with no academic administrative experience. The Senior Vice Provost, a magnificently meticulous administrator with an engineering background and a passion for university policy, reviewed our work diligently, methodically, and critically. As comments, corrections, and changes emerged weekly from the provost's office, we struggled to keep traction with the committees. Of course, the scrutiny by the USC administration was totally appropriate; after all, it was their school. But at the time, this extra "help," relatively late in the game, felt painfully bureaucratic and created an instantaneous "taffy pull" over control, which further threatened the already strained timelines.

This made for difficult circumstances. I was working with people who could care less that I was a chair of surgery. Indeed, the surgery personality stereotype usually made being a surgeon a liability. For the first time in my professional career, I was in charge of something in which I was losing total control. With a true sense of vulnerability, I found myself driven less by creativity and more by fear of failure. Primal instincts emerged. Failure would not be an option. My pace quickened, making my already truncated nights even shorter. As we pushed the committees, the enormity of the project, the stress of the internal politics and the pressure of the timelines also became apparent to the Institutional Self-Study Task Force. All eyes turned to me for encouragement and guidance (or so I perceived). While privately I felt like the blind leading the blind, publicly I found myself rallying behind committees, encouraging them, praising their ideas, earnestly embracing their creativity, and instilling ownership. Suddenly, I realized I was behind the herd. I had become a shepherd, not by purposeful intention but by necessity and self-preservation. Slowly but surely, as well, I was transforming into a different person. Maybe it was exhaustion or maybe it was conscious leadership, but I had become a different type of leader.

Looking back, my transformation was not subtle. It was very apparent to many. One day, one of my junior faculty, a surgeon whom I trained and mentored since medical school, made an appointment to see me. He was concerned by my transformation and was convinced that the change was a consequence of the disrespectful Consultant. Despite my best efforts, I was unable to make my junior faculty member understand that I was a consenting co-conspirator of this transformation. Finally giving up,

I conceded that he was correct. I explained that the Consultant was actually brought in by the GHS administration to be my "Life Coach" in an attempt to modify my boorish leadership style. Interestingly, he found this explanation to be totally credible and left my office completely satisfied. In my new state of self-awareness, I found this to be quite enlightening. To elicit this kind of reaction, what kind of leader had I been all these years and what was trying to emerge?

THE TURNING POINT—"THROUGH ME"

Dr Michael Whitcomb, in a report for the Macy Foundation examining the current wave of emerging and new medical schools, concluded that there are four barriers common to all start-ups. These are finances, availability of appropriate facilities, affiliations with a major teaching hospital, and favorable political alignments.[7] While the USCSOM Greenville is blessed with a secure financial plan (which includes a recurring revenue stream from the hospital obviating the need for state appropriations), adequate facilities (Fig 5), and a robust health system, it almost succumbed to failure because of political misalignment. This misalignment occurred mostly at the regional/state level. Despite not requesting state appropriations, a vocal faction of South Carolina legislators strongly opposed USCSOM Greenville. This created a public debate, played out mostly in the print media. The state politics consumed the attention of our governmental/public relations team, altered our timelines and further compromised our control over the project. For most of 2010, our work was being performed under a firmament of uncertainty. At times, it was difficult to keep people focused because of the threat of political failure. Moreover, the public political battle posed a serious barrier when it came to recruiting faculty, most of whom had secure jobs in established medical schools. The most critical administrative/faculty need was in the area of curriculum development. For this, we had contracted Lynn Crespo, PhD, from the University of Central Florida College of Medicine as a consultant. While Dr Crespo was interested in full-time employment at USCSOM Greenville (as were we), the political uncertainty proved to be prohibitive.

In June 2010, USCSOM Greenville faced its most challenging period. State politics were at their most intense, and the timelines for the submission of LCME documents were closing quickly. Most problematic, the medical school had no dedicated full-time leadership. Typically, new and emerging medical schools start by naming a full-time leader, usually called the Founding Dean. Politics precluded this in our case. Our management team was being directed, part-time, by the chair of surgery, constantly leaving open the question of institutional commitment to both proponents and detractors. Seemingly the last straw occurred in mid-June when we learned that the senior USC administration, presumably in response to the intense political scrutiny from lawmakers in Columbia, decided to hire an outside consulting firm to understand better the risks and benefits of the second

Fig 5. The Health Sciences Education Building housing the M1 and M2 years for the University of South Carolina School of Medicine Greenville.

medical school in Greenville. While at face value this sounded reasonable, it would require time—time that we simply did not have. As the barriers seemed to mount against us, one obstacle, the perceived lack of full-time leadership, was one I could do something about. Perhaps through fear of failure or a feeling that something larger was trying to emerge, I had convinced myself that some symbol of commitment, an act of personal vulnerability, was needed to persuade others to join our cause. So after 12 years of leading the department of surgery, all of its members whom I had either recruited or trained, I stepped down as chair, without promise of a job, to devote my full attention to the school of medicine.

Personally, I believe that this was one of several turning points. My actions, indeed, provided a spark of assurance big enough to convince Dr Crespo to join us as associate dean for education. She came immediately to Greenville and began to help write documents. Everything became easier. Committees jelled, the writing was better, morale improved, and the timelines suddenly appeared achievable. While momentum appeared to be turning in our favor, the most providential turn of events was yet to come. When the University scheduled me to meet with their consultant, acquired to re-look at the whole plan, I discovered that the consultant was a man named Richard Dean. To my amazement, it turned out to be Richard Dean, MD, of Winston-Salem, NC, vascular surgeon, friend, and mentor as well as Past President of the Southern Association for Vascular Surgery! The consulting engagement immediately shifted from an impregnable impediment to a providential enabler. The Cavalry had arrived, just in the nick of time. Through pure fate, we had acquired an ally, a surgeon who was able to efficiently and effectively bridge the culture between the university and the health system. Over the ensuing weeks, Dr Dean helped us weather the internal politics and co-manage the timelines. The final result was that USCSOM Greenville submitted a completed database and self-study to the LCME in time to be considered for a charter class in 2012.

Epilogue. On October 4, 2011, while in Boston testing with the American Board of Surgery, I received

a message from Founding Dean Jerry Youkey informing me that the LCME had granted Preliminary Accreditation to USCSOM Greenville, making it the 136th medical school in North America. This allowed us to begin the admissions process for our 2012 charter class. On July 31, 2012, USCSOM Greenville welcomed its first class, which immediately began Emergency Medical Technology training as part of the M1 curriculum. This class of 53 individuals was selected from an applicant pool of over 1400 applications. USCSOM Greenville joins the ranks of the new millennial medical schools, known as the Macy schools. To my knowledge, it is the only medical school in existence founded as a consequence of actions by four southern vascular surgeons—Edward Floyd, MD, Jerry Youkey, MD, Spence Taylor, MD, and Richard Dean, MD.

Shortly after Jerry Youkey was named Founding Dean, I was named GHS Vice President for Academics/Designated Institutional Official, Executive Medical Director of the University Medical Group (our employed physician group), and Senior Associate Dean for Academic Affairs and Diversity in the medical school. For my worried family, whom I am sure questioned my sanity at times during the medical school development process, to be offered a job of any sort was a great relief. For me, the adventure continues.

In April 2011, Dr Andrew Sorensen died suddenly and unexpectedly after a routine morning bike ride. His impact on my personal and professional development, which was significant, can never be repaid. Andrew was a great man and one of my lifelong heroes. It is regretful that he was unable to meet the charter class of students at USCSOM Greenville. He would have been so proud.

Lastly, we are anxiously anticipating the LCME provisional accreditation process, a requirement when the charter class finishes its M2 year. That means we will have the opportunity to reassemble the Institutional Self-Study Task Force during the summer of 2013. I have my Life Coach's telephone number on speed dial and my shepherd's crook at the ready.

SURGEONS AS LEADERS: APPLYING THE LESSONS LEARNED

As I look back on the process of creating the USCSOM Greenville, I am filled with immense pride, appreciation, gratitude, and wonder. But I must confess that during the most trying times, I was convinced that we were producing an inferior product, a product mired with compromise. I felt forced out of control, often the bystander. I had to trust people I did not know. I had to rely on creativity to avoid conflict, even though I would have preferred to have forced my will. Because I possessed limited knowledge about the subject matter, I approached the project with uncharacteristic curiosity. I listened to opinions from numerous people without judgment since I had no opinion to defend. I had to rely on wisdom instead of knowledge. Yet, while forced from my comfort zone, I felt liberated. I realized how much effort I expend in my life simply trying to be right. For the first time, I was a participant, a facilitator, and co-creator of something that was trying to emerge, not something I was trying to control. And more than anything else, I was attuned to my faults and shortcomings. How was I showing up? Did I prove to be an effective leader despite knowing less than many whom I led? While experiencing self-doubt and constant self-reflection, I was forced to shift and to ask the tough questions about me as a person and a leader.

I have come to realize that the USCSOM Greenville is not a compromised product; it is an amazing product. While it did not occur despite me, it did not occur because of me. I am fine with that. I will be eternally grateful for having had the opportunity to lead the team that created this medical school. It has changed me forever—pure appreciation. As well, I have come to understand that perhaps for the first time in my life, I led, using authentic self-effacing communication, in "by me" mentality; and through surrender, actually experienced life as "through me."

My experience with USCSOM Greenville does little to prove or disprove my hypothesis that lack of self-awareness is a blind spot prohibiting vascular surgeons from leadership beyond our traditional domain. All I can say is that it certainly was a blind spot in my case. Acknowledging that my story will not resonate with all, I challenge you, and especially individuals who hear and reject this message, to inwardly reflect. Like me, you may be the least self-aware and the most in need its lessons. When I observe the behavior of surgeons, and vascular surgeons in particular, several patterns emerge that support my hypothesis. As a group, we tend to be self-absorbed. We righteously choose to "go it alone"—to be concerned only with the immediate affairs of vascular surgery even though our subspecialty, which successfully reinvented itself in the 2000s, has so much to offer to others. We bemoan change, blaming and complaining and often invest great effort to resist it. We work in silos and often duplicate infrastructure. We expend great energy defending our actions as being right and fail to realize that the opposing point of view is equally as true and just as right to someone else. Lastly and perhaps foremost, we fail to appreciate that all of these behaviors are rarely productive. Substantive change will occur only if we become more aware of our behavior and our actions. As a specialty, how are we showing up in the world? Are we showing up as victims, at the effect of societal change, or are we taking healthy responsibility to help shape a better way? Asking these questions is a characteristic of a self-aware specialty capable of providing better leaders.

There are many challenges and opportunities for our specialty today—challenges and opportunities greater than starting a medical school. But like starting a medical school, I doubt we will be successful in addressing our concerns until we understand more about why we act the way we do. To be successful, we must be willing to step out of our comfort zone. We must become more self-aware. Are we willing to make that shift? Vascular surgeons are incredible creatures. We are creative, intelligent, adaptable, industrious, and passionate.

We have the capacity to make our world a better place. The question is, "Are we willing to surrender and to see what is trying to emerge through us?"

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